APPENDIX B

EPSDT STANDARDS AND TRACKING FORMS

AHCCCS EPSDT TRACKING FORMS

The AHCCCS EPSDT Tracking Forms must be used by providers to document all age-specific, required information related to EPSDT screenings and visits. Only the AHCCCS forms may be used; paper form substitutes are not acceptable. If Provider chooses to utilize an electronic EPSDT form, this electronic substitute will be acceptable provided the following conditions are met:

1. Provider's electronic form includes all fields that are present on the AHCCCS EPSDT form.

2. In the future AHCCCS may create an electronic EPSDT form. In that event, provider agrees to convert to AHCCCS electronic EPSDT form.

AHCCCS Contractors are required to make these forms available to their contracted providers. Interested persons may refer to Chapter 400 in this Manual for a discussion of EPSDT responsibilities and services.

A copy of the completed form signed by the clinician should be placed in the member's medical record.

If the member is enrolled with an AHCCCS Contractor, a copy of the completed and signed form must be sent to that Contractor.

If the patient is an AHCCCS fee-for-service member (e.g., enrolled in Indian Health Services), the provider should maintain a copy of the EPSDT tracking form in the medical record, but does not need to send a copy elsewhere.

AHCCCS Contractors and AHCCCS medical providers may reproduce the EPSDT forms as needed. All others may reproduce the forms with permission of the Arizona Health Care Cost Containment System. Written requests for the Tracking Forms may be directed to:

AHCCCS
Division of Health Care Management
CQM/Maternal and Child Health
701 E. Jefferson, Mail Drop 6500
Phoenix, AZ 85034
(602) 417-4410

NOTE: The Centers for Medicare and Medicaid Services require AHCCCS to provide specified services to our EPSDT population. These EPSDT Tracking Forms have been designed to ensure that needed services are performed, and that our members are provided an opportunity to receive preventive care. ***Please do NOT alter or amend these forms in any way without discussion with our Maternal and Child Health Manager at the address above.***

Contact information for AHCCCS' subcontracted health care plans may be found at www.ahcccs.state.az.us.

Revised: 11/01/2007, 01/01/2004, 11/01/2003, 06/01/2003
Effective: 07/01/2001

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Allergies:	Temp:	Pulse:	Resp:

Medications:	Birth wt:	Wt:	%	Length:	%	Head circ:	%

Hospital Newborn Hearing Screen: ☐ ABR ☐ OAE: **Rt. ear** ☐ pass ☐ refer **Lt. ear** ☐ pass ☐ refer ☐ Unknown
Second Newborn Hearing Screen (if 2nd needed/completed): ☐ ABR ☐ OAE: **Rt. ear** ☐ pass ☐ refer **Lt. ear** ☐ pass ☐ refer ☐ Unknown

PARENTAL CONCERNS/HISTORY: How are you feeling about baby? Do you feel safe in your home?

NUTRITIONAL SCREEN: [X] **INDICATES GUIDANCE GIVEN:** ☐ Breast feeding ☐ Formula: _____
☐Adequate intake ☐ Supplements:

DEVELOPMENTAL SCREEN: [X] **INDICATES ACCOMPLISHMENT:** ☐ Rooting reflex ☐ Startle ☐ Suck & swallow ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] **INDICATES GUIDANCE GIVEN:** ☐ Supine sleep ☐ Car seat/rear facing ☐ Infant bonding ☐ Bottle prop ☐ Passive smoke ☐ Support/who can help? ☐ Infant crying/what to do? ☐ Safe bathing/water temperature ☐ Shaken baby prevention ☐ Guns ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] **INDICATES OBSERVED BY CLINICIAN/PARENT REPORT:** ☐ Family Adjustment/parent responds positively to child ☐ Length of time infant cries ☐ Encourage holding ☐ Infant hands to mouth/self calming ☐ Other

COMPREHNSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: [X] **INDICATES ORDERED** ☐ 2nd Newborn screening **(5 – 10 days of age or first PCP visit)** ☐ Other

IMMUNIZATIONS: [X] **INDICATES ORDERED** ☐ 1st Hepatitis B vaccine date: _____ ☐ Pt. Needs immunization today
☐ Shot record initiated ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason

REFERRALS: [X] **INDICATES REFERRED** ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Speech ☐ AzEIP/ DDD ☐ Developmental ☐ Behavioral ☐ Specialty ☐ Early Head Start ☐ 2nd Newborn hearing screening **(if needed)** ☐ Other

_____ See Additional Supervisory
Date/Time Clinician name (print) Clinician Signature note ☐**Yes** ☐**No**

1 Month Old — AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Allergies:	Temp:	Pulse:	Resp:

Medications:	Birth wt:	Wt:	%	Length:	%	Head circ:	%

Hospital Newborn Hearing Screen: ☐ ABR ☐ OAE: **Rt. ear** ☐ pass ☐ refer **Lt. ear** ☐ pass ☐ refer ☐ Unknown
Second Newborn Hearing Screen (if 2nd needed/completed): ☐ ABR ☐ OAE: **Rt. ear** ☐ pass ☐ refer **Lt. ear** ☐ pass ☐ refer ☐ Unknown

PARENTAL CONCERNS/HISTORY: How are you feeling about the baby? Do you feel safe in your home?

NUTRITIONAL SCREEN: [X] **INDICATES GUIDANCE GIVEN:** ☐ Breast fed ☐ Formula: _____ ☐ Cereal ☐ Adequate intake ☐ Supplements:

DEVELOPMENTAL SCREEN: [X] **INDICATES ACCOMPLISHMENT:** ☐ Responds to sounds ☐ Responds to parent's voice ☐ Follows with eyes ☐ Awake for 1 hour stretches ☐ Beginning Tummy Time Play ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] **INDICATES GUIDANCE GIVEN:** ☐ Supine sleep ☐ Car seat/rear facing ☐ Infant bonding ☐ Bottle prop☐ Support/who can help? ☐ Infant crying/what to do? ☐ Safe bathing/water temperature ☐ Shaken baby prevention ☐ Passive smoke ☐ Emergency/911 ☐ Sun safety ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] **INDICATES OBSERVED BY CLINICIAN/PARENT REPORT:** ☐ Family Adjustment/parent responds positively to child ☐ Length of time infant cries ☐ Infant hands to mouth/self calming ☐ Encourage holding ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED:	[X] **INDICATES ORDERED** ☐ 2nd Newborn screening **(5 – 10 days of age or first PCP visit)** ☐ Other
IMMUNIZATIONS:	[X] **INDICATES ORDERED** ☐ 1st Hepatitis B vaccine date: _____ ☐ Pt. Needs immunization today ☐ Shot record initiated ☐ 2nd Hepatitis B vaccine date: _____ ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason
REFERRALS:	[X] **INDICATES REFERRED** ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Speech ☐ AzEIP/DDD ☐ Developmental ☐ Behavioral ☐ Early Head Start ☐ Specialty ☐ 2nd Newborn hearing screen **(if needed)** ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐**Yes** ☐**No**

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2 Months Old — AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Allergies:	Temp:	Pulse:	Resp:

Medications:	Birth wt:	Wt:	%	Length:	%	Head circ:	%

Risk indicators of hearing loss: ☐ **yes** ☐ **no**
Hospital Newborn Hearing Screen: ☐ ABR ☐ OAE: **Rt. ear** ☐ pass ☐ refer **Lt. ear** ☐ pass ☐ refer ☐ Unknown
Second Newborn Hearing Screen (if 2nd needed/completed): ☐ ABR ☐ OAE: **Rt. ear** ☐ pass ☐ refer **Lt. ear** ☐ pass ☐ refer ☐ Unknown

PARENTAL CONCERNS/HISTORY:

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Breast fed ☐ Formula: _____
☐ Cereal ☐ Adequate intake ☐ Supplements:

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENT: ☐ Some Head Control ☐ Coos, babbles ☐ Makes Eye Contact ☐ Fixes/follows with eyes ☐ Begins imitation of movement and facial expressions ☐ Tummy Time/ lifts head, neck with forearm support ☐ Startles at loud noises ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Supine sleep ☐ Car seat/rear facing ☐ Infant bonding ☐ Bottle prop ☐ Support/who can help? ☐ Infant crying/what to do ☐ Safe bathing/water temperature ☐ Shaken baby prevention ☐ Pacifiers ☐ Passive smoke ☐ Emergency/911 ☐ Sun safety ☐ Parent reads to child ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family Adjustment/parent responds positively to child ☐ Length of time infant cries ☐ Infant hands to mouth/self calming ☐ Encourage holding ☐ Social smile ☐ Enjoys interacting with others ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED:	[X] INDICATES ORDERED ☐ 2nd Newborn screening **(if needed)** ☐ Other
IMMUNIZATIONS:	[X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ Hepatitis B ☐ DTaP ☐ Hib ☐ IPV ☐ PCV ☐ Rotavirus ☐ Other
REFERRALS:	[X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Speech ☐ AzEIP/DDD ☐ Developmental ☐ Behavioral ☐ Early Head Start ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐**Yes** ☐**No**

4 Months Old — AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Birth Wt:	Allergies:	Temp:	Pulse:	Resp:

Risk indicators of hearing loss: ☐ yes ☐ no	Medications:	Wt:	%	Length:	%	Head circ:	%

PARENTAL CONCERNS/HISTORY:

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Breast fed ☐ Formula: _____
☐ Cereal ☐ Plan to introduce solids_____
☐ Soda/Juice ☐ Adequate intake ☐ Supplements:

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENTS ☐ Babbles and coos ☐ ☐ Smiles ☐ Begins to roll front to back ☐ Pushes up with arms ☐ Controls head well ☐ Reaches for objects ☐ Interest in mirror images ☐ Pushes down with legs when feet on surface ☐ Looks at you with eyes ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Car seat/rear facing ☐ Emergency 911 ☐ Bottle prop ☐ Support/who can help? ☐ Infant crying/what to do? ☐ Safe bathing/water temperature ☐ Shaken baby prevention ☐ Establish daily routines/infant regulation ☐ Establish nighttime sleep routine/sleep through night=5 hours ☐ Introduce child temperament/easy/sensitive ☐ Passive smoke ☐ Parent reads to child ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family Adjustment/Parent responds positively to baby ☐ Length of time infant cries ☐ Infant hands to mouth/self calming ☐ Smiles when hears parents' voice ☐ Encourage holding ☐ Easily distracted/excitement of discovery of outside world ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: [X] INDICATES ORDERED ☐

IMMUNIZATIONS: [X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ Hepatitis B ☐ DTaP ☐ Hib ☐ IPV ☐ PCV ☐ Rotavirus ☐ Other

REFERRALS: [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ Speech ☐ AzEIP/ DDD ☐ Developmental ☐ Early Head Start ☐ Behavioral ☐ Specialty ☐ Other

_____ See Additional Supervisory note ☐**Yes** ☐**No**

Date/Time Clinician name (print) Clinician Signature

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6 Months Old — AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Birth Wt:	Allergies:	Temp:	Pulse:	Resp:

Risk indicators of hearing loss: ☐ yes ☐ no	Medications:	Wt:	%	Length:	%	Head circ:	%

PARENTAL CONCERNS/HISTORY:

VERBAL LEAD RISK ASSESSMENT: [X] INDICATES GUIDANCE GIVEN: At risk ☐ yes ☐ no (if yes, a blood lead test is required)

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Adequate intake ☐ Breast fed ☐ Formula: _____ ☐ Rice cereal ☐ Solids ☐ Soda/Juice ☐ Supplements:

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENTS ☐ "Dada, baba" babbles ☐ Rolls over ☐ Transfers small objects ☐ Vocal imitation ☐ Sits with support ☐ Explores with hands and mouth ☐ Peek-a-boo/patty cake ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Drowning prevention ☐ Emergency 911 ☐ Sun safety ☐ Baby proofing ☐ Car seat/rear facing ☐ Introduce board books/mouthing ☐ Introduce cup ☐ Passive smoke ☐ Teething/tooth brushing ☐ Sleep/wake cycle ☐ Parent reads to child ☐ Refrain from jump seat/walker ☐ Begin using high chair ☐ Other

BEHAVIORAL HEALTH SCREEN:: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT ☐ Family Adjustment/parent responds positively to baby ☐ Encourage holding ☐ Self calming ☐ Wary of strangers ☐ Recognizes familiar people ☐ Distinguishes emotions by tone of voice ☐ Enjoys social play ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: [X] INDICATES ORDERED ☐

IMMUNIZATIONS: [X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ Hepatitis B ☐ DTaP ☐ Hib ☐ IPV ☐ PCV ☐Influenza ☐ Rotavirus ☐ Other

REFERRALS: [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ Speech ☐ AzEIP/ DDD ☐ Developmental ☐ Behavioral ☐ Early Head Start ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐**Yes** ☐**No**

9 Months Old — AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Birth Wt:	Allergies:	Temp:	Pulse:	Resp:

Risk indicators of hearing loss: ☐ yes ☐ no	Medications:	Wt:	%	Length:	%	Head circ:	%

PARENTAL CONCERNS/HISTORY:

VERBAL LEAD RISK ASSESSMENT: [X] INDICATES GUIDANCE GIVEN: At risk ☐ yes ☐ no (if yes, a blood lead test is required)

ORAL SCREENING: [X] INDICATES GUIDANCE GIVEN: ☐ Brushing teeth ☐ White spots on teeth

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Adequate intake ☐ Breast fed ☐ Formula: _____ ☐ Soda/Juice ☐ Solids ☐ Supplements:

DEVELOPMENTAL SCREEN: ☐ Goes from sitting to all fours ☐ Peek-a-boo ☐ Uses words such as "mama/dada" ☐ Sits independently ☐ Repeats sounds/gestures for attention ☐ Explores environment ☐ Waves bye-bye ☐ Drinks from cup ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Drowning prevention ☐ Emergency 911 ☐ Sun Safety ☐ Baby proofing ☐ Car seat/rear facing ☐ Sleep/wake cycle ☐ Wary of strangers ☐ Introduce board books ☐ Soft texture finger foods/choking ☐ Redirection/positive parenting ☐ Exploration/learning ☐ Passive smoke ☐ Language/read to child ☐ Follow child's lead in play ☐ Parent communicates to child "what things are"(ball, cat etc) ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family Adjustment/parent responds positively to child ☐ Encourage holding ☐ Self calming ☐ Growing Independence ☐ Shows preference for certain people/toys ☐ Cries when primary care giver leaves ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: [X] INDICATES ORDERED ☐ Hgb/Hct **(perform at 9 months)** ☐ Other

IMMUNIZATIONS: [X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ Hepatitis B ☐ DTaP ☐ Hib ☐ IPV ☐ PCV ☐ Influenza ☐ Other

REFERRALS: [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ Speech ☐ AzEIP/DDD ☐ Developmental ☐ Behavioral ☐ Early Head Start ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐**Yes** ☐**No**

12 Months Old — AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Birth Wt:	Allergies:	Temp:	Pulse:	Resp:

Risk indicators of hearing loss: ☐ yes ☐ no	Medications:	Wt:	%	Length:	%	Head circ:	%

PARENTAL CONCERNS/HISTORY:

DENTAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Daily tooth brushing ☐ First dental appointment White spots on teeth ☐ yes ☐ no

NUTRITIONAL SCREEN:: [X] INDICATES GUIDANCE GIVEN: ☐ Breast fed ☐ Formula:_____
☐ Adequate intake Solids: _____
☐ Supplements_____ ☐ Soda ☐ Juice

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENTS: ☐ First steps ☐ "Mama" "dada" specific ☐ Uses single words ☐ Scribbles ☐ Precise pincer grasp ☐ Follows simple one step requests ☐ Looks for hidden objects ☐ Extends arm/leg for dressing ☐ Point to/label pictures ☐ Plays: hides object/pushes ball back and forth ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Drowning prevention ☐ Emergency 911 ☐ Sun safety ☐ Passive smoke ☐ Car seat safety/20#'s AND 1 year = forward facing ☐ Weaning plan/milk intake ☐ Discipline/praise ☐ Follow child's lead in play ☐ Ignore tantrums/give attention to positive behaviors ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family adjustment/parent responds positively to child ☐ Self calming ☐ Prefers primary care giver over all others ☐ Shy/anxious with strangers

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine (scoliosis)		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP:

LABS ORDERED:	[X] INDICATES ORDERED ☐ Blood Lead Test **(perform at 12 months)** ☐.TB skin test **(if at risk)** ☐Other
IMMUNIZATIONS:	[X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ Had chicken pox ☐ Hep A ☐ HepB ☐ MMR ☐ Varicella ☐ DtaP ☐ Hib ☐ IPV ☐ PCV ☐ Influenza
REFERRALS:	[X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ Speech ☐ AzEIP/ DDD ☐ Developmental ☐ Behavioral ☐ Early Head Start ☐ Dental ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐**Yes** ☐**No**

Revised November 1, 2007

15 Months Old — AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Birth Wt:	Allergies:	Temp:	Pulse:	Resp:

Risk indicators of hearing loss: ☐ yes ☐ no	Medications:	Wt:	%	Length:	%	Head circ	%

PARENTAL CONCERNS/HISTORY:

VERBAL LEAD RISK ASSESSMENT: [X] INDICATES GUIDANCE GIVEN: At risk ☐ yes ☐ no (if yes a blood lead test is required)

DENTAL SCREENING: [X] INDICATES GUIDANCE GIVEN: ☐ Brushing daily ☐ 1st Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐Feeds self ☐ Breast fed/whole milk ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements _____ ☐ Solids

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENTS: ☐ Says 3-6 words ☐ Says No ☐ Wide range of emotions ☐ Repeats words from conversation ☐ Knows one color ☐ Understands simple commands ☐ Climbs stairs ☐ Walking ☐ Puts objects in container and takes object out of container ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Drowning prevention ☐ Emergency 911 ☐ Sun safety ☐ Car seat safety/40#'s/4 years ☐ Gentle limit setting/redirection/safety ☐ Reading/parent asks child "what's that?" ☐ Manage growing independence/defiant behavior ☐ Follow child's lead in play ☐ Offer opportunity to scribble/explore ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family adjustment/parent responds positively to child ☐ Encourage holding ☐ Self calming ☐ Frustration/hitting/biting/impulse control ☐ Communication/language ☐ Social interaction/eye contact/comforts others ☐ Begins to have definite preferences ☐ Other

UUCOMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: [X] INDICATES ORDERED ☐ TB skin test (if at risk)

IMMUNIZATIONS: [X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ History of chicken pox ☐ HepA ☐ HepB ☐ MMR ☐ Varicella ☐ DTaP ☐ Hib ☐ IPV ☐ PCV ☐ Influenza ☐ Other

REFERRALS: [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ Speech ☐ AzEIP/DDD ☐ Developmental ☐ Behavioral ☐ Dental ☐ Early Head Start ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐**Yes** ☐**No**

Revised November 1, 2007

18 Months Old — AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Allergies:	Temp:	Pulse:	Resp:

Risk indicators of hearing loss: ☐ yes ☐ no	Medications:	Birth Wt:	Wt:	%	Length:	%	Head circ:	%

PARENTAL CONCERNS/HISTORY:

VERBAL LEAD RISK ASSESSMENT: [X] **INDICATES GUIDANCE GIVEN:** At risk ☐ yes ☐ no

DENTAL SCREEN: [X] **INDICATES GUIDANCE GIVEN:** ☐ Brushing daily ☐ 1st Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: [X] **INDICATES GUIDANCE GIVEN:** ☐ Breast fed/whole milk ☐ Feeds self ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements _____ ☐ Solids

DEVELOPMENTAL SCREEN: [X] **INDICATES ACCOMPLISHMENTS** ☐ Uses a cup ☐ Walks ☐ Says 10-20 words ☐ Says "No" ☐ Name one picture/2 colors/ ☐ Follows simple rules/bring me the book ☐ Knows animal sounds ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] **INDICATES GUIDANCE GIVEN:** ☐ Drowning prevention ☐ Emergency 911 ☐ Discipline/limits ☐ Read to child ☐ Dental caries prevention ☐ Sibling interaction ☐ Nutrition/mealtimes ☐ Defiant behavior/offer child choices ☐ Never leave toddler alone ☐ Growing independence ☐ Encourage expression of wide range of emotions ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] **INDICATES OBSERVED BY CLINICIAN/PARENT REPORT:** ☐ Family adjustment/parent responds positively to child ☐ Encourage holding ☐ Self calming ☐ Frustration/hitting/biting/impulse control ☐ Communication/language ☐ Demonstrates increasing independence ☐ Begins to show defiant behavior ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: [X] **INDICATES ORDERED** ☐ TB skin test (if at risk) Other ☐

IMMUNIZATIONS: [X] **INDICATES ORDERED** ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ History of chicken pox ☐ HepA ☐ HepB ☐ MMR ☐ Varicella ☐ DTaP ☐ Hib ☐ IPV ☐ PCV ☐ Influenza ☐ Other

REFERRALS: [X] **INDICATES REFERRED** ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ Speech ☐ AzEIP/DDD ☐ Developmental ☐ Behavioral ☐ Dental ☐ Early Head Start ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐**Yes** ☐**No**

24 Months Old — AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Allergies:	Temp:	Pulse:	Resp:

Risk indicators of hearing loss: ☐ yes ☐ no	Medications:	Birth Wt:	Wt:	%	Ht:	%	Head circ:	%

PARENTAL CONCERNS/HISTORY:

DENTAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Brushing/flossing **(by parent)** ☐ 1st Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Feeds self ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENTS: ☐ Kicks a ball ☐ stacks 5-6 blocks ☐ 20 word vocabulary ☐ Walks up stairs/runs well ☐ Communicates needs in 2-4 word sentences ☐ Names 6 body parts Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Sleep practices ☐ Drowning prevention ☐ Emergency 911 ☐ Sun safety ☐ Nutrition/exercise ☐ Toilet training ☐ Discipline/redirection/praise ☐ read to child ☐ Car safety/booster seat/5 pt harness ☐ Learns 5-6 words every week ☐ Provide opportunities for success/choice: 2 items "juice or milk"/"red or blue shirt" ☐ Praise for effort/success ☐ Establish daily routine ☐ Encourage/support wide range of emotions ☐ Trike/bike safety ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family adjustment/parent responds positively to child ☐ Encourage holding ☐ Self calming ☐ Frustration/hitting/biting/impulse control ☐ Communication/language ☐ Sense of humor ☐ Demonstrates increasing independence ☐ Plays alongside peers ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED:	[X] INDICATES ORDERED ☐ Blood Lead test **(perform at 24 months)** ☐ TB skin test **(if at risk)** ☐ Other
IMMUNIZATIONS:	[X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ Had chicken pox ☐ HepA ☐ HepB ☐ MMR ☐ Varicella ☐ DTaP ☐ Hib ☐ IPV ☐ PCV ☐ Influenza ☐ Other
REFERRALS:	[X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ ST ☐ AzEIP/DDD ☐ Developmental ☐ Behavioral ☐ Dental ☐ Early Head Start ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐**Yes** ☐**No**

Revised November 1, 2007

3 Years Old — AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS ☐ yes ☐ no	PEDS Pathway:	Vision Chart Exam OD	OS	OU	Allergies:	Temp:	Pulse:	Resp:	B/P
Hearing Screening ☐ Unable to perform			Corrected ☐ yes ☐ no			Wt:	%	BMI:	%	Ht:	%
Rt. ☐ pass ☐ refer Lt. ☐ pass ☐ refer			☐ Unable to perform								
Speech: age appropriate ☐ yes ☐ no		Medications:									

PARENTAL CONCERNS/HISTORY:

DENTAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Brushing/flossing **(by parent)** daily ☐ Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: : ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENTS ☐ Uses imaginary characters ☐ Matches colors and shapes ☐ Counts to 5 ☐ Names self and others ☐ Knows gender ☐ Begins to play: games with simple rules/interactive games ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE:: [X] INDICATES GUIDANCE GIVEN: ☐ Sport helmet use ☐ Drowning prevention ☐ Emergency 911 ☐ Sun safety ☐ Nutrition/exercise ☐ Toilet training ☐ Discipline/redirect ☐ Reading/preschool ☐ Car Safety/booster seat/5 pt harness ☐ Provide opportunities for pretend & fantasy/problem solving & choices/drawing & scribbling ☐ Establish routine for: bed/meals/toileting etc. ☐ Allow child to play independently/be available if child seeks you out ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family adjustment/parent responds positively to child ☐ Self calming ☐ "Monster" fear ☐ Frustration/hitting/biting/impulse control ☐ Communication/language ☐ Pediatric Symptom Checklist ☐ Has words for feelings ☐ Separates easily from parent ☐ Objects to major change in routine ☐ Shows interest in other children ☐ Feels competent ☐ Kind to animals ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED:	[X] INDICATES ORDERED ☐ Hgb/Hct ☐ Urinalysis ☐ TB skin test (if at risk) ☐ Blood Lead Test **(perform at 36 – 72 months if not already done)** ☐ Other
IMMUNIZATIONS:	[X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent Refuses ☐ Other reason ☐ Had chicken pox ☐ HepA ☐ HepB ☐ MMR ☐ Varicella ☐ DTaP ☐ Hib ☐ IPV ☐ PCV ☐ Influenza ☐ Other
REFERRALS:	[X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ DDD ☐ ALTCS ☐PT ☐OT ☐ Audiology ☐ST ☐ Developmental ☐ Behavioral ☐ Dental ☐ Head Start ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐**Yes** ☐**No**

4 Years Old — AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS ☐ yes ☐ no	PEDS Pathway:	Vision Chart Exam OD	OS	OU	Allergies:	Temp:	Pulse:	Resp:	B/P
Hearing Screening ☐ Unable to perform			Corrected ☐ yes ☐ no			Wt:	%	BMI:	%	Ht:	%
Rt. ☐ pass ☐ refer Lt. ☐ pass ☐ refer			☐ Unable to perform								
Speech: age appropriate ☐ yes ☐ no			Medications:								

PARENTAL CONCERNS/HISTORY:

DENTAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Brushing/flossing **(by parent)** daily ☐ Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: : ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENTS: ☐ Sings a song ☐ Draws a person with 3 parts ☐ Gives first/last name ☐ Names 6-8 colors/3 shapes ☐ Counts 1-7 objects out loud (not always in order) ☐ Names self and others ☐ Shows interest in other children ☐ Plays interactive with simple rules ☐ Asks/answers who, what, where, why ☐ Follows 2 unrelated directions ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Sport helmet use ☐ Drowning prevention ☐ Emergency 911 ☐ Sun safety ☐ Safe at Home ☐ Nutrition/exercise ☐ Toilet training ☐ Discipline/redirect ☐ Reading/preschool ☐ Car Safety/booster seat/5 pt harness ☐ Provide opportunities for pretend & fantasy/problem solving & choices/drawing & scribbling ☐ Establish routine for bed/meals/toileting etc. ☐ Allow child to play independently/be available if child seeks you out ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family adjustment/parent responds positively to child ☐ Self calming ☐ Communication/language ☐ Pediatric Symptom Checklist ☐ Separates easily from parent ☐ Feels competent ☐ Kind to animals ☐ Objects to major change in routine ☐ Has words for feelings ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: [X] INDICATES ORDERED ☐ Hgb/Hct ☐ Urinalysis ☐ TB skin test (if at risk) ☐ Other ☐ Blood Lead Test **(perform at 36 – 72 months if not already done)**

IMMUNIZATIONS: [X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ Had chicken pox ☐ HepA ☐ HepB ☐ MMR ☐ Varicella ☐ DTaP ☐ Hib ☐ IPV ☐ Influenza ☐ PCV ☐ Other

REFERRALS: [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ DDD ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ Speech ☐ Developmental ☐ Behavioral ☐ Dental ☐ Head Start ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐**Yes** ☐**No**

5 Years Old — AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS ☐ yes ☐ no	PEDS Pathway:	Vision Chart Exam OD	OS	OU	Allergies:	Temp:	Pulse:	Resp:	B/P
Hearing Screening ☐ Unable to perform			Corrected ☐ yes ☐ no			Wt:	%	BMI:	%	Ht:	%
Rt. ☐ pass ☐ refer Lt. ☐ pass ☐ refer			☐ Unable to perform								
Speech: age appropriate ☐ yes ☐ no			Medications:								

PARENTAL CONCERNS/HISTORY:

DENTAL SCREEN : [X] **INDICATES GUIDANCE GIVEN:** ☐ Brushing 2x /Flossing daily ☐ Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: [X] **INDICATES GUIDANCE GIVEN: :** ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements

DEVELOPMENTAL SCREEN: [X] **INDICATES ACCOMPLISHMENTS** ☐ Recognizes most letters/shapes/numbers to 10 ☐ Recognize/identify some letters and phonic sounds ☐ Sorts and counts up to 5 objects ☐ Holds pencil ☐ Cuts with scissors ☐ Cooperates more in group setting ☐ Runs/skips/jumps ☐ Begins to agree with rules ☐ Can button and zip clothing independntly ☐ Goes to bathroom independently ☐ Likes to sing/dance/act ☐ Knows address ☐ Plays board games ☐ Dictates story to adults ☐ Listens to authority figure and follows instructions ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] **INDICATES GUIDANCE GIVEN:** ☐ Sport/bike helmet use ☐ Drowning prevention ☐ Emergency 911 ☐ Sun safety ☐ Safe at home ☐ Nutrition/exercise ☐ Street safety ☐ Discipline/redirect ☐ Reading ☐ School readiness ☐ Set only 3-5 rules for your child ☐ Car seat <40 lbs/belt positioning booster seat <4'9''/air bags ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] **INDICATES OBSERVED BY CLINICIAN/PARENT REPORT** ☐ Family adjustment/parent responds positively to child ☐ Self calming ☐ Communication/language ☐ Pediatric Symptom Checklist ☐ Shows empathy for others ☐ Wants to please & be with friends ☐ Positive about self & abilities ☐ Tells stories of convenience(lying) ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: [X] **INDICATES ORDERED** ☐ Hgb/Hct ☐ Urinalysis **(to be completed at 5 years)** ☐ TB skin test **(if at risk)** ☐ Other ☐ Blood Lead Test **(perform at 36 – 72 months if not already done)**

IMMUNIZATIONS: [X] **INDICATESORDERED** ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ Had chicken pox ☐ HepA ☐ HepB ☐ MMR ☐ Varicella ☐ DTaP ☐ IPV ☐ Influenza ☐ Other

REFERRALS: [X] **INDICATES REFERRED** ☐ CRS ☐ WIC ☐ DDD ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ ST ☐ Developmental ☐ Behavioral ☐ Dental ☐ Specialty

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐**Yes** ☐**No**

Revised November 1, 2007

6 Years Old — AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS ☐ yes ☐ no	PEDS Pathway:	Vision Chart Exam OD	OS	OU	Allergies:	Temp:	Pulse:	Resp:	B/P

Audiometry		Corrected ☐ yes ☐ no	Wt:	%	BMI:	%	Ht:	%
☐ WNL	☐ Abnormal							

Speech: age appropriate ☐ yes ☐ no	Medications:

PARENTAL CONCERNS/HISTORY:

DENTAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Brushing 2x /Flossing daily ☐ Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: : ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENTS ☐ Language is expressive and understandable ☐ School attendance ☐ Reading at grade level ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Sport/bike helmet use ☐ Drowning prevention ☐ Emergency 911 ☐ Sun safety ☐ Safe at Home ☐ Nutrition/exercise ☐ Street safety ☐ Discipline/redirect ☐ Reading ☐ School readiness ☐ Belt positioning booster seat <4'9''/air bags ☐ Provide opportunities for social interaction/invite friends over to play board games/dress up etc. ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family adjustment/parent responds positively to child ☐ Frustration/impulse control ☐ Communication/language ☐ Has friends ☐ Plays well with others/by self ☐ Is liked by other children ☐ Feels capable ☐ Expresses full range of emotions ☐ Pediatric Symptom Checklist ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: [X] INDICATES ORDERED ☐ Hgb/Hct ☐ Urinalysis ☐ TB skin test (if at risk) ☐ Other ☐ Blood Lead Test **(perform at 36 – 72 months if not already done)**

IMMUNIZATIONS: [X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ Had chicken pox ☐ HepA ☐ HepB ☐ MMR ☐ Varicella ☐ DTaP ☐ IPV ☐ Influenza ☐ Other

REFERRALS: [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ DDD ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ ST ☐ Developmental ☐ Behavioral ☐ Dental ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐**Yes** ☐**No**

7 – 8 Years Old AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS ☐ yes ☐ no	PEDS Pathway:	Vision Chart Exam			Allergies:	Temp:	Pulse:	Resp:	B/P
			OD	OS	OU					
Audiometry			Corrected ☐ yes ☐ no			Wt:	%	BMI:	%	Ht: %
☐ WNL	☐ Abnormal									
Speech: age appropriate ☐ yes ☐ no		Medications:								

PARENTAL/PATIENT CONCERNS/HISTORY:

DENTAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Brushing 2x /Flossing daily ☐ Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: : ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENTS: ☐ School attendance ☐ Reading at grade level ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Sport/bike helmet use ☐ Drowning prevention ☐ Emergency 911 ☐ Sun safety ☐ Safe at Home ☐ Nutrition/exercise ☐ Street safety ☐ Discipline ☐ Reading ☐ School readiness ☐ Belt positioning booster seat <4'9''/air bags ☐ Bullying ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT ☐ Family adjustment/parent responds positively to child ☐ Frustration /impulse control ☐ Communication/language ☐ Comfortable body image ☐ Pediatric Symptom Checklist ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED:	[X] INDICATES ORDERED ☐ Hgb/Hct ☐ Urinalysis ☐ TB skin test (if at risk) ☐ Other
IMMUNIZATIONS:	[X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed ☐ Deferred ☐ Hep A ☐ MMR ☐ Varicella ☐ Td ☐ Influenza ☐ Hep B ☐ IPV ☐ Other
REFERRALS:	[X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ DDD ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ ST ☐ Developmental ☐ Behavioral ☐ Dental ☐ Specialty

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐**Yes** ☐**No**

9 – 12 Years Old — AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

Vision Chart Exam				Audiometry		Menses		Allergies:		B/P:	Temp:	Pulse:	Resp:
OD	OS	OU	☐ Unable to perform	☐ WNL	☐ Abnl	☐ yes ☐ no							
Corrected ☐ yes ☐ no				☐ Unable to perform		Menarche	LMP	Wt:	%	BMI:	%	Ht:	%
Medications:													

PARENTAL/PATIENT CONCERNS:

HEALTH RISK ASSESSMENT: ☐ Early Adolescent GAPS (begin at 10 years) ☐ Other

DENTAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Brushing 2x /Flossing daily ☐ Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: : ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENTS: Early adolescence: ☐ School attendance ☐ Reading at grade level ☐ Dating ☐ Sexuality/orientation ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Sports/injury prevention ☐ Drowning/sun safety ☐ Nutrition/exercise ☐ Safe at Home ☐ Seat belt/air bags ☐ Sex education/STI ☐ Peer refusal skills ☐ Violence prevention/gun safety ☐ Depression/anxiety ☐ Tobacco/alcohol/drugs/Rx drugs/inhalants ☐ Education goals/activities ☐ Social interaction ☐ Risks of tattoos/ piercing ☐ After school activities/supervision ☐ Bullying ☐ Self control ☐ Other

Behavioral Health Screen: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT ☐ Comfortable body image ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary **Tanner stage_____**		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: [X] INDICATES ORDERED ☐ Hgb/Hct ☐ Urinalysis ☐ Lipid Profile TB skin test (if at risk) ☐ Other

IMMUNIZATIONS: [X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed ☐ Deferred ☐ Tdap **(11 - 12years only)** ☐ Meningococcal **(11 – 12 years only)** ☐ HPV **(11 – 12 years)** ☐ Hepatitis A ☐ MMR ☐ Varicella ☐ Hepatitis B ☐ Td ☐ Influenza ☐ IPV ☐ Other

REFERRALS: [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ DDD ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ Speech ☐ Developmental ☐ Behavioral ☐ Dental ☐ Specialty

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐**Yes** ☐**No**

Revised November 1, 2007

13 – 17 Years Old AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

Vision Chart Exam				Audiometry		Menses	Allergies:			B/P	Temp:	Pulse:	Resp:
OD	OS	OU	☐ Unable to perform	☐ WNL	☐ Abnl	☐ yes ☐ no							
Corrected ☐ yes ☐ no				☐ Unable to perform		Menarche	LMP	Wt:	%	BMI:	%	Ht:	%
Medications:													

Parent/Patient Concerns/History:

HEALTH RISK ASSESSMENT: ☐ HEADDSS ☐ GAPS ☐ Other

DENTAL SCREENING: [X] **INDICATES GUIDANCE GIVEN:** ☐ Brushing 2x /Flossing daily ☐ Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: [X] **INDICATES GUIDANCE GIVEN: :** ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements

DEVELOPMENTAL SCREEN: [X] **INDICATES ACCOMPLISHMENTS:** Middle Adolescence: ☐ School attendance ☐ Reading at grade level ☐ Dating ☐ Sexuality/orientation ☐ Risk taking (Learning to drive 15 to 17 years) ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] **INDICATES GUIDANCE GIVEN:** ☐ Sports/injury prevention ☐ Drowning/sun safety ☐ Nutrition/exercise ☐ Safe at Home ☐ Seat belt/air bags ☐ Sex education/STD/resources ☐ Self control ☐ Peer refusal skills ☐ Bullying ☐ Violence prevention/gun safety ☐ Depression/anxiety ☐ Tobacco/alcohol/drugs/Rx drugs/inhalants ☐ Education goals/activities ☐ Social interaction ☐ Sexual orientation/dating ☐ Risks of tattoos/ piercing ☐ Availability of family planning services ☐ After school activities/supervision ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] **INDICATES OBSERVED BY CLINICIAN/PARENT REPORT:** ☐ Comfortable body image ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary **Tanner stage_____**		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN & FOLLOW UP

LABS ORDERED: [X] **INDICATES ORDERED** ☐ Hgb/Hct ☐ U/A **(preferred at 16 yrs)** ☐ Lipid Profile ☐ TB skin test (if at risk) ☐ Other

IMMUNIZATIONS: [X] **INDICATES ORDERED** ☐ Pt. Needs immunization today ☐ Delayed ☐ Deferred ☐ Hepatitis A ☐ MMR ☐ Varicella ☐ Hepatitis B ☐ Tdap ☐ Influenza ☐ Meningococcal ☐ HPV ☐ IPV ☐ Td ☐ Other

REFERRALS: [X] **INDICATES REFERRED** ☐ CRS ☐ WIC ☐ DDD ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ Speech ☐ Developmental ☐ Behavioral ☐ Dental ☐ Specialty

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐**Yes** ☐**No**

18 – 21 Years Old — AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

Vision Chart Exam				Audiometry		Menses	Allergies:			B/P	Temp:	Pulse:	Resp:
OD	OS	OU	☐ Unable to perform	☐ WNL	☐ Abnl	☐ yes ☐ no							
Corrected ☐ yes ☐ no				☐ Unable to perform		Menarche	LMP	Wt:	%	BMI:	%	Ht:	%
Medications:													

Patient Concerns/History:

HEALTH RISK ASSESSMENT: [X] INDICATES ASSESSMENT USED: ☐ HEADDSS ☐ GAPS ☐ Other

DENTAL SCREENING: [X] INDICATES GUIDANCE GIVEN: ☐ Brushing 2x /Flossing daily ☐ Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: : ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENTS: Late Adolescence: ☐ Abstract thinking ☐ School attendance ☐ Sexuality/orientation ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Sports/injury prevention ☐ Athletic activities ☐ Drowning/sun safety ☐ Nutrition/exercise ☐ Safe at Home ☐ Seat belt/air bags ☐ Sex education/STD/resources ☐ Self control ☐ Peer refusal skills ☐ Violence prevention/gun safety ☐ Depression/anxiety ☐ Tobacco/alcohol/drugs/Rx drugs/inhalants ☐ Education goals/activities ☐ Social interaction/dating ☐ Parenting advice **(as appropriate)** ☐ Future oriented ☐ Risks of tattoos/ piercing ☐ Availability of family planning services ☐ Job/career planning ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Philosophical/idealistic ☐ Comfortable body image ☐ Building intimate, complex relationships ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary **Tanner stage_____**		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: [X] INDICATES ORDERED ☐ Hgb/Hct ☐ Urinalysis ☐ Lipid Profile ☐ TB skin test (if at risk) ☐ Other

IMMUNIZATIONS: [X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed ☐ Deferred ☐ Hepatitis A ☐ MMR ☐ Varicella ☐ Hepatitis B ☐ Tdap ☐ Influenza ☐ Meningococcal ☐ HPV ☐ IPV ☐ Td ☐ Other

REFERRALS: [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ DDD ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ Speech ☐ Developmental ☐ Behavioral ☐ Dental ☐ OB/Gyn ☐ Specialty

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐**Yes** ☐**No**